

COMPLICATIONS OF VOMITING

4. Kelley DK, Neugebauer MK, Fosburg RG: Spontaneous intramural esophageal perforation. *J Thorac & Cardiovasc Surg* 63:504-508, Mar 1972
5. Benjamin B, Hanks TJ: Submucosal dissection of the esophagus due to haemorrhage: A new radiographic finding. *J Laryngol & Otol* 79:1032-1038, Jul 1965
6. Thompson NW, Ernst CB, Fry WJ: The spectrum of emetogenic injury to the esophagus and stomach. *Am J Surg* 113:13-26, Jan 1967
7. Smith G, Gillanders LA, Brunnen PL, et al: Oesophageal apoplexy. *Lancet* 1:390-392, Mar 1974
8. Boerhaave H: "Atrocis, nec descripti: Pruis, morbi historia"—*Secundum medicae artis leges conscripta*, Ludg. Bat. Boulesleugiane, 1724, translated in *Bull M Libr Assoc* 43:217-240, Apr 1955
9. Mackler SA: Spontaneous rupture of the esophagus; a clinical and experimental study. *Surg Gynecol & Obstet* 95:345-356, 1952
10. Bódi T, Fanger H, Forsythe T: Spontaneous rupture of the esophagus. *Ann Int Med* 41:553-562, Sept 1954
11. Barrett NR: Report of a case of spontaneous perforation of the esophagus successfully treated by operation. *Brit J Surg* 35:216-218, Jul 1947
12. Sherr HP, Light RW, Mersin MH, et al: Origin of pleural fluid amylase in esophageal rupture. *Ann Int Med* 76:985-986, Jun 1972
13. Derbes VJ, Mitchell RE: Rupture of the esophagus. *Surgery* 39:688-709, 865-888, Apr-May, 1956
14. Zikria BA, Rosenthal AN, Potter RT, et al: Mallory-Weiss syndrome and emetogenic (spontaneous) rupture of the esophagus. *Ann Surg* 162:151-155, Jul 1964
15. Mallory GK, Weiss S: Hemorrhages from lacerations of the cardiac orifice of the stomach due to vomiting. *Am J Med Sci* 178:506-515, Oct 1929
16. Weaver DH, Maxwell JG, Castleton KB: Mallory-Weiss syndrome. *Am J Surg* 118:887-892, Dec 1969
17. Nielsen PE, Zachariae F: The Mallory-Weiss syndrome. *Acta Pathologica et Microbiologica Scand, Sec A, Pathol Suppl* 212:Suppl 212:166-175, 1970
18. Watts HD, Admirand WH: Mallory-Weiss syndrome: A reappraisal. *JAMA*—in press
19. Fleischner FG: Hiatal hernia complex: Hiatal hernia, peptic esophagitis, Mallory-Weiss syndrome, hemorrhage and anemia, and marginal esophagogastric ulcer. *JAMA* 162:183-191, Sep 15, 1956
20. Sparberg M: Roentgenographic documentation of the Mallory-Weiss syndrome. *JAMA* 203:151-152, Jan 8, 1968
21. Carr JC: The Mallory-Weiss syndrome. *Clin Radiol* 24:107-112, Jan 1973
22. Pitcher JL: Cardial balloon tamponade in the treatment of the Mallory-Weiss syndrome. *Gastrointest Endosc* 18:122-124, Mar 1972
23. Dagradi AE, Broderick JT, Juler G, et al: The Mallory-Weiss syndrome and lesion: A study of 30 cases. *Am J Dig Dis* 11:710-721, Sep 1966
24. Dill JE, Wells RF, Levy M: The Mallory-Weiss syndrome: Some unusual presentations and a suggested new therapy. *Gastrointest Endosc* 18:157-158, Apr 1972
25. Palmer ED: The vigorous diagnostic approach to upper gastrointestinal tract hemorrhage. *JAMA* 207:1477-1480, Feb 24, 1969

Legal Implications of Laparoscopic Complications

LET ME JUST COVER THE HIGHLIGHTS of what might concern you in regard to laparoscopy. The informed consent doctrine applies differently in different states. Some states require more disclosures by physicians to patients than do other states in order to secure an adequately-informed legal consent. But let me try to give some minimal concept as to what probably would protect you in most states. If we can avoid considering laparoscopy as simple (and we can always avoid telling a patient it is simple) you have avoided 90 percent of the problem of informed consent. It's as simple as that. You never, never tell a patient that any laparoscopic procedure, either for diagnostic or therapeutic purposes, is simple; and you will have avoided most of the problems associated with it.

I think that all of your laparoscopic procedures should have some type of written consent form. Somewhere in the middle of the form, put the statement that this procedure, like all operative procedures, may be subject to serious complications or even death. You can use that language somewhere in the middle of your form. Now, I am not telling you to list all of the complications. I'm not telling you not to, either. But if that is the minimal disclosure required, I don't think it is going to harm many patients. First of all, they have to read it. Second of all, they have to understand it. And most patients realize the generalities of "serious complications or death." And as long as there is evidence of some type of disclosure on a minimal basis such as that, I think you've avoided another 9 percent of the problem, in addition to the 90 percent avoided by not telling them it's simple. If there is any question concerning the indications for the procedure, then you have to go farther. There's no way of justifying the performance of a non-indicated procedure without the patient's knowing it's not indicated . . . or without the patient's knowing that there are questions concerning its indications. If that's true, then you've got to disclose it and go further in terms of the risks involved, so that the patient is then making a decision along with you as to whether the procedure should be performed at all . . ."

—DON H. MILLS, MD, JD, *Los Angeles*
 Extracted from *Audio-Digest Obstetrics and Gynecology*, Vol. 21, No. 3, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1930 Wilshire Blvd., Suite 700, Los Angeles, CA 90057.